

Social worker: Amanda Jane Seaward

Registration number: SW20948

Fitness to Practise

Final Hearing

Dates of hearing: 08 June 2026 to 24 June 2026

Hearing venue: Remote hearing

Hearing outcome:

Fitness to practise impaired, suspension order (2 years)

Interim order:

Interim suspension order (18 months)

Introduction and attendees:

1. This is a hearing held under Part 5 of The Social Workers Regulations 2018 (as amended) (“the regulations”).
2. Ms Amanda Seaward did not attend and was not represented.
3. Social Work England was represented by Ms Louise Culleton, case presenter from Capsticks LLP.
4. The panel of adjudicators conducting this hearing (hereafter “the panel”) and the other people involved in it were as follows:

Adjudicators	Role
Timothy Skelton	Chair
Natalie Pickles	Social Worker adjudicator
Olivia Kong	Lay adjudicator

Hearings team/Legal adviser	Role
Hannah Granger	Hearings officer
Chiugo Eze	Hearings support officer
Gemma Gillet	Legal adviser

Service of notice:

5. The panel was informed by Ms Culleton that notice of this hearing was sent to Ms Amanda Seaward by email and next day special delivery service to an address provided by the Ms Seaward (namely their registered address as it appears on the Social Work England register). Ms Culleton submitted that the notice of this hearing had been duly served.
6. The panel had careful regard to the documents contained in the final hearing service bundle as follows:
 - A copy of the notice of the final hearing dated 30 April 2026 and addressed to Ms Seaward at her email and postal address which she provided to Social Work England;
 - An extract from the Social Work England Register as of 30 April 2026 detailing Ms Seaward’s registered postal and email address;
 - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 30 April 2026 the writer sent by email and next day delivery to Ms Seaward at the address referred to above: notice of hearing and related documents;
 - A copy of the Royal Mail Track and Trace Document indicating “signed for” delivery to Ms Seaward’s address at 10.23 am on 01 May 2026.
7. The panel accepted the advice of the legal adviser in relation to service of notice.

8. Having had regard to Rules 14, 15, 44, 45 and all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Ms Seaward in accordance with the Rules.

Proceeding in the absence of the Ms Seaward:

9. The panel heard the submissions of Ms Culleton on behalf of Social Work England. Ms Culleton submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Ms Seaward and as such there was no guarantee that adjourning today's proceedings would secure her attendance. Ms Culleton further submitted that Ms Seaward appears to have voluntarily absented herself. Ms Culleton reminded the panel that there had been no substantive response from Ms Seaward, other than to indicate on 13 October 2013 that she does not intend to continue to work as a social worker or maintain her registration. She therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.
10. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to Rule 43 of the Rules and the cases of *R v Jones [2002] UKHL 5*; *General Medical Council v Adeogba [2016] EWCA Civ 162*. The panel also took into account Social Work England guidance 'Service of notices and proceeding in the absence of the Ms Seaward'.
11. The panel considered all of the information before it, together with the submissions made by Ms Culleton on behalf of Social Work England. The panel noted that Ms Seaward had been sent notice of today's hearing and the panel was satisfied that she was or should be aware of today's hearing.
12. The panel noted that Ms Seaward had engaged in a telephone call with Social Work England on 13 October 2023 in response to information about the regulator's investigation. On that occasion Ms Seaward stated that she did not intend continuing her registration (when it expired in November 2023) and was not currently working in the profession nor did she intend to return to work in the profession. She asked whether these proceedings were necessary in those circumstances. The panel also had sight of an email from Ms Seaward dated 18 December 2023 asking for documents to be resent as she had been unable to open a bundle. The panel noted that Ms Seaward had not engaged and had not responded to any of the more recent communication she had been sent, including previous emails attaching draft evidence bundles and Direction Orders.
13. The panel therefore concluded that Ms Seaward had chosen voluntarily to absent herself and had no reason to believe that an adjournment would result in her attendance. Having weighed the interests of Ms Seaward in regard to their attendance at the hearing with those of Social Work England and the public interest in an expeditious disposal of this hearing, the impact on witnesses who have been warned to attend and the impact on their memory of any further delay, the panel determined to proceed in Ms Seaward's absence. The panel also considered that it would not be in Ms Seaward's best interests to delay these proceedings any further.

Preliminary matters:

14. Ms Culleton informed the panel that in preparation for a final hearing, Social Work England consider the evidence which it intends to rely on, and any additional relevant evidence is served on a registrant or their representatives as unused material. The registrant then has an opportunity to consider the unused material and decide if it is evidence they would like to rely on. Ms Culleton informed the panel that in this case, unused material had been provided to Ms Seaward which included a statement and evidence provided by Cynthia Henry, who had acted as Mr Seaward's supervisor from January 2021, during the earlier period of the allegations.
15. Ms Culleton told the panel that in light of Ms Seaward's non-engagement and non-attendance the unused material had been reviewed. Ms Culleton submitted that although Social Work England were not relying on Ms Henry as a witness, it was fair that the panel have sight of the document at this stage as she was less critical of the Ms Seaward's conduct in relation to service user I and K.
16. Ms Culleton also submitted that her evidence provides some background information regarding the level of supervision, equipment provided and Ms Seaward's health matters which were supported by the team.
17. The panel heard and accepted the advice from the legal adviser, that it had a wide discretion to admit evidence at any stage if it considered it relevant and fair to do so.
18. The panel noted that Ms Seaward has been sent the documents in question as unused material and that Social Work England were now asking for the statement and exhibits to be included out of fairness to the registrant. The panel was satisfied that the evidence appears to provide relevant information to specific allegations, and general background which is likely to be helpful during its deliberation. The panel therefore agreed that the evidence be added to the panel's bundle. After considering the statement and exhibits the panel asked that Ms Henry be called to give evidence.
19. Ms Culleton also alerted the panel for the likely need to address issues relating to Ms Seaward's health during the hearing, the panel agreed that it would be appropriate for the hearing to be conducted in private when such issues arise.

Application to amend allegation 10 (a)

20. Ms Culleton applied to amend Allegation 10 (a) by changing the end date from 13 November 2022 to 6 November 2022. This was to ensure consistency with the dates set out elsewhere in the allegation and to reflect the evidence that 6 November 2022 was Ms Seaward's last day of employment before suspension. The Panel agreed to the amendment.

Allegations:

21. The allegation arising out of the regulatory concerns referred by the Case Examiners on 12 September 2024 is:

Whilst registered as a social worker, and whilst employed by North Northamptonshire County Council, in the period between January 2021 to 6 November 2022:-

1. *With respect to Service User A, you:-*
 - a. *Upon allocation on 21 July 2021,*
 - i. *Failed to make timely contact/attempt contact with Service User A;*
 - ii. *Failed to undertake a visit to Service User A in a timely manner;*
 - b. *Failed to respond to telephone calls from Service User A's stepson on 23 and/or 26 and/or 29 July 2021, in a timely manner;*
 - c. *Failed to action and/or progress a safeguarding referral in respect of Service User A received on 2 August 2021 from East Midlands Ambulance Service.*
2. *With respect to Service User B, you:-*
 - a. *Following a number of referrals received from 7 – 19 July 2021, and upon allocation on 21 July 2021,*
 - i. *Failed to make timely contact/attempt contact with Service User B and/or the referrers;*
 - ii. *Failed to undertake a visit to Service User B in a timely manner;*
 - b. *Further to 2 (a) above, failed to respond in a timely way to a phone call from the referrer on 25 August 2021;*
 - c. *Failed to adequately action and/or progress the safeguarding referrals received in respect of Service User B.*
3. *With respect to Service User C, you:-*
 - a. *Following allocation on or around 28 June 2021,*

- i. Failed to make timely contact/attempt contact with Service User C;*
 - ii. Failed to undertake a visit to Service User C in a timely manner;*
 - b. Further to 3 (a) above, between 15 July 2021 and 25 August 2021, failed to follow up, and/or to record any follow up, to seek to establish contact with Service User C, in order to enable her care package to be reassessed.*
- 4. With respect to Service User D, you:-*
 - a. Following allocation on 23 June 2021,*
 - i. Failed to make timely contact/attempted contact with Service User D;*
 - ii. Failed to undertake a visit to Service User D in a timely manner;*
 - b. Following 15 July 2021 having called Service User D an ambulance at his request during a telephone call with you, did not follow up with Service User D and/or the hospital.*
- 5. With respect to Service User E, you:-*
 - a. Following allocation on 14 June 2021:-*
 - i. Failed to make timely contact/attempt contact with Service User E;*
 - ii. Failed to undertake a visit to Service User E in a timely manner;*
 - b. As a result of 5(a) above, failed to take appropriate action in relation to safeguarding concerns in a timely manner or at all.*
- 6. With respect to Service User F, you:-*
 - a. Following allocation on 9 June 2021,*
 - i. Failed to make timely contact/attempt contact with Service User F;*

- ii. Failed to undertake a visit to Service User F in a timely manner;
 - b. Between 15 July 2021 and 6 August 2021, failed to adequately consider and assess Service User F's needs.
7. With respect to Service User G, you:-
 - a. Failed to attend and/or record attendance at arranged visits to Service User G on 22 June 2021 and/or 20 July 2021;
 - b. Failed to make and/or record any contact with Service User G and/or their family between 11 August 2021 and 7 September 2021;
 - c. Following voicemail messages from Service User G's family on 7 and/or 9 September 2021, did not respond in a timely manner or at all;
 - d. As a result of any or all of 7 (a) – 7 (c), failed to adequately consider and assess Service User G's needs;
 - e. Failed to complete a Care Act Assessment.
8. With respect to Service User H, you:-
 - a. Following referrals received on 20 and 21 July 2021, failed to make timely contact/attempt contact with the referrer and/or Service User H;
 - b. As a result of 8(a) above, failed to adequately consider and assess Service User H's needs and/or caused a delay to Service User H receiving community support;
 - c. From around 18 August 2021 when Service User H was ready to be discharged form hospital, failed to adequately follow up and/or action necessary next steps, including:-
 - i. Advising on referring for a telephone lifeline;
 - ii. Completing an assessment for a community care package;
 - d. Failed to adequately action and/or progress the safeguarding referrals received in respect of Service User H.
9. With respect to Service User I, you:-

- a. *Following allocation on 19 January 2021,*
 - i. *Failed to make timely contact/attempted contact with Service User I and or/the referrer;*
 - ii. *Failed to undertake a visit to Service User I in a timely manner;*
- b. *Following carrying out an assessment of Service User I on 18 February 2021, failed to*
 - i. *Make contact with Service User I's family in a timely way;*
 - ii. *Complete the assessment;*
 - iii. *Respond to an email from one of Service User I's sons complaining about lack of contact and involvement;*
- c. *Following a safeguarding concern being raised on 16 March 2021, did not take any, or any adequate action, in a timely way, to gather information and/or assess risk and/or commence a Care Act Assessment;*
- d. *Following concerns being raised by the hospital on 29 April 2021, did not take any action or any adequate action;*
- e. *Following a further safeguarding concern being raised on 7 May 2021, did not take any action or any adequate action;*
- f. *Failed to respond to the hospital's requests for updates on 3 and/or 8 June 2021 in a timely way, or at all;*
- g. *Between 23 June 2021 and 9 July 2021 failed to follow up or review the case;*
- h. *Failed to attend, or failed to record attendance at, a visit to Service User I on 12 July 2021.*

10. With respect to Service User J, you:-

- a. *Between around 11 May 2022 and 13 November 2022 did not make and/or record adequate progress on the case;*
- b. *On or around 17 October 2022, took possession of Service User J's mobile phone;*

- c. *On or around 17 October 2022, made no record of having taken possession of Service User J's mobile phone or the reasons for having done so;*
- d. *Following information received from Service User J's father on 17 October 2022, did not follow up with other relevant parties/bodies (Service User J's college and the police), in a timely way;*
- e. *As a result of any or all of 10 (a) – (d) above, failed to take appropriate action in relation to safeguarding concerns.*

11. *With respect to Service User K, you:-*

- a. *Following a failed visit to Service User K on 4 November 2022 did not adequately follow up and/or liaise with other relevant parties;*
- b. *Failed to adequately complete the safeguarding concern that had been raised.*

12. *With respect to Service User L, you:-*

- a. *Following a telephone call from Service User L's son on 10 June 2022, failed to communicate with him and/or other service providers in a timely way;*
- b. *Failed to maintain adequate communications with Service User L's family between 8 and 29 July 2022 and/or update the records to record any communications that there had been in that time period;*
- c. *Between 24 August and 3 November 2022, failed to adequately progress the actions required including:-*
 - i. *Addressing/raising the Safeguarding and Notification of Concern that had been raised;*
 - ii. *Following up with the care provider;*
 - iii. *Discussions with Service User L's son;*
 - iv. *Discussion with Service User L.*
- d. *Failed to adequately record contact with Service User L's son.*

13. *With respect to Service User M, you:-*

- a. *Between around 27 April 2022 and 9 October 2022, failed to adequately progress the case in a timely way, and/or record actions taken to progress the case in a timely way including in respect of:-*
 - i. *Carrying out a visit to Service User M on 4 May 2022;*
 - ii. *Scheduling multi-disciplinary team meetings;*
 - iii. *From around 23 June 2022, progressing agreed actions to follow up with the GP and/or environmental health and/or the RSPCA and/or the police;*
 - iv. *From around 23 June 2022, addressing the safeguarding concern that had been raised.*

14. *With respect to Service User N, you:-*

- a. *Following allocation to Service User N on 4 May 2022,*
 - i. *Failed to make timely contact/attempted contact with Service User N;*
 - ii. *Failed to arrange and/or undertake a visit to Service User N in a timely manner.*
- b. *Following visiting Service User N on 30 May 2022, you failed to adequately progress the matter in a timely way and/or adequately complete the records and required documentation including in respect of:-*
 - i. *Initial contact/conversation 1 paperwork;*
 - ii. *Follow up with Service User N;*
 - iii. *Follow up with the housing application.*

15. *With respect to Service User O, you:-*

- a. *Between 30 May and November 2022, you did not adequately progress the matter, including in respect of:*
 - i. *Conversation 1 and 2;*
 - ii. *Transfer to the 'Inclusion Team' (P2P);*

iii. Speaking to Service User O and/or recording having spoken to Service User O;

iv. Adult Risk Management meetings and/or paperwork.

16. Your conduct at any or all of paragraphs 1 to 15 failed to safeguard the service users set out therein.

The matters described at paragraphs 1 - 16 above amount to lack of competence/capability

Your fitness to practise as a Ms Seaward is impaired by reason of your lack of competence/capability.

Summary of evidence:

22. In advance of the hearing the panel was provided with a number of bundles, including;
- A Statement of Case;
 - A 150-page statement bundle;
 - A 1835-page exhibits bundle; and
 - A 14-page Ms Seaward Response bundle.
23. Social Work England provided a written explanation of the background of the concerns within the statement of case, as follows;

On 19 April 2022, Social Work England received a referral from Meriel White, Team Manager, regarding the Respondent Ms Seaward, Amanda Jane Seaward (“the Ms Seaward”).

The Ms Seaward was employed at North Northamptonshire County Council (“the Council”) as a principal care manager within the Wellingborough Community Adult Social Care Team (“the Community Hub”) from October 2020 until her employment ended on 20 October 2023. She had previously been employed by the Council since 2003.

The Referral to Social Work England was as a result of an investigation undertaken by the Council. The Council audited a number of case files that the Ms Seaward was responsible for. As a result, concerns were identified with the Ms Seaward not having contacted service users and service providers in a timely manner, not having taken appropriate action in respect of safeguarding concerns in a timely

manner, or at all, and not having ensured that her case records were updated accurately and/or in a timely manner.

The case concerns the Registrant's practice in respect of Service Users A – O over a period from January 2021 to 6 November 2022, following which she was suspended, and which spanned a period of time before a Performance Improvement Plan ("PIP") was put in place as well as after it had been put in place following the initial investigation.

Initially Ms White became aware of concerns as a result of people chasing for updates and contact with the Ms Seaward which led her to have concerns around the Ms Seaward's performance. Ms White therefore reviewed some of the Ms Seaward's cases in August 2021 and identified the concerns raised in this case around adequately progressing cases and a lack of contact between the Ms Seaward and service users, their families and other service providers. The Ms Seaward was then suspended in September 2021.

The Council initially initiated disciplinary proceedings, following concerns raised as above in respect of Service Users A – I.

An investigation report was produced in November 2021, by Michelle Wright, who had been appointed to conduct the investigation.

A disciplinary hearing took place on 14 January 2022. The outcome was a final written warning to be on her file for 18 months.

The Ms Seaward was at this stage, made subject to a Performance Improvement Plan, which commenced on 7 December 2021, although came into effect when the Ms Seaward returned from leave in early January 2022. Alongside this she had supervision and On-Track Chats ("OTCs") with Lisa Buttar, her supervisor.

In respect of the period from March 2022, when Ms Buttar became involved in an oversight capacity, to 11 November 2022 when the Ms Seaward was once again suspended, ongoing similar concerns were raised with the Ms Seaward's practice and handling of the cases of a number of Service Users J and K.

It was on 13 October 2022, that a performance review took place whereby the Ms Seaward's progress was reviewed. It was determined that the Ms Seaward's performance continued to be below the required standard including in respect of lack of proactive contact with vulnerable individuals allocated to her, not progressing case work in a timely manner, not completing case notes which were

reflective of working practice, or recording all work completed and safeguarding concerns not being followed up on, with no paperwork completed around this.

The First Formal Meeting under the Improving Performance Policy then took place on 16 November 2022. Given the conclusion that the Ms Seaward's performance remained below the required standard, a further Formal PIP would be agreed with a further monitoring period of eight weeks.

As a result, there was a further disciplinary investigation, the Ms Seaward being suspended on 11 November 2022 and the case was then referred to a disciplinary hearing. Ms Lisa Rooney carried out the investigation at this time. The disciplinary hearing was held on 28 July 2023.

Further to Social Work England's investigation a number of other similar concerns were raised in respect of Service Users L, M, N and O.

24. The panel heard evidence from the following witnesses (titles given at the positions are the time of the allegations);
- **Meriel White**, Ms Seaward, Team Manager at the Community Wellingborough Hub of North Northamptonshire Council ("the Council");
 - **Lisa Buttar**, Principal Ms Seaward at the Council;
 - **Lisa Rooney (nee Smith)**, Team Manager for the Transitions Team (now Moving into Adulthood Team, Complex Continuing Health Care and Transforming Care at the Council;
 - **Ellen Nicholas** (nee Harris), Ms Seaward in the Community Wellingborough Hub at the Council;
 - **Amy Dundas**, Ward Matron, Orchard Ward, St Mary's Hospital;
 - **Cynthia Henry**, Ms Seaward and Ms Seaward's supervisor in 2021; and
 - **Michelle Wright**, Safeguarding Team Manager, at the Council;
25. Ms Culleton, on behalf of Social Work England confirmed that she did not have any questions for Ms Valerie Goryll, daughter of Service User G, who had provided a witness statement. The panel carefully considered her statement and noted that her evidence provided very helpful information about the impact of the alleged delay in the progression of her mother's case, but contained no new information to assist the panel in their deliberation on the facts. The panel therefore confirmed that it did not have any questions for the witness and she was no longer required to attend.

26. Ms Seaward did not attend and had not provided a substantive response to the concerns during Social Work England's investigation or in advance of the final hearing. The panel was mindful that Ms Seaward had provided a response to some of the issues when raised by her employer during internal investigations and disciplinary procedures.

Meriel White

27. Ms White attended and adopted the contents of her witness statement dated 23 December 2025 as her primary evidence, subject to minor amendments. In her oral evidence, Ms White informed the panel that:
- She believed there had been inadequacies in the level of supervision Ms Seaward had received at the beginning of the relevant period which meant issues were not picked up as quickly as they should have been.
 - The concerns about the initial level of supervision were taken into account when drawing conclusions from the first performance investigation/hearing, as it was felt Ms Seaward should be given a new supervisor who could provide her with very specific guidance about what was expected and what to prioritise. It was hoped this would lead to improvements.
 - Despite the additional guidance provided by her new supervisor which included regular "on track chats" and follow up emails with very specific instructions, Ms Seaward still failed to meet the expectations regarding timescales and the progression of cases.
 - Ms White was confident that the whole team were aware of the expectations regarding timescales and the expected safeguarding processes. The timescales were set by the safeguarding board, which social workers were expected to follow to ensure they are properly assessing and reacting to risk. She was specifically confident that Ms Seaward was aware of the expectations as she was able to provide guidance on what was required to other members of the team.
 - The expectations for the social workers in the team were that once a case had been allocated to them, contact would be made within 48 hours.
 - Ms Seaward was the most experienced social worker in the team at the time, with 13 years' experience and she would have been undertaking capacity assessments etc on a regular basis. The team had received specific training on any issues which might have been "new", for example working with people with dementia. There was no material difference between working with older people and other vulnerable people, for example those with mental health concerns.
 - Ms Seaward had a case load of about 18 cases, which was below the number expected for a full-time member of staff within the team.

- By way of example, in relation to Service User A, Ms White was concerned that Ms Seaward had not responded to a safeguarding referral from an ambulance team for nearly 3.5 weeks.
- In relation to Service User B, Ms White was concerned that Ms Seaward had not called or visited the service user or progressed the case in any meaningful way, from the date it was allocated to her on 28 June 2021 until a telephone call on 6 September 2021.
- [PRIVATE]
- Ms White confirmed that when she conducted her audit she looked at all 18 cases which had been allocated to Ms Seaward at the relevant time. She had serious concerns about time scales and progression for 11 of the cases. The remaining 5 had been jointly worked on with a second social worker who appeared to be responsible for having met the requirements. Ms White also confirmed that the panel had sight of the complete file notes for the cases in question but that the format varied depending on who and how the information had been exported.

Lisa Buttar

28. Lisa Buttar attended and confirmed and adopted the contents of her witness statement dated 16 December 2025. In addition, she told the panel that;

- In March 2022, she had been asked to have oversight of the cases allocated to the Ms Seaward as it was thought it would be beneficial to have a fresh set of eyes. To do this, she had sight of the improvement plan but had played no role in the development of the plan. She was aware that the Ms Seaward's productivity was far below what was expected.
- She was also asked to have oversight of the cases and to undertake consistent "on track chats" with Ms Seaward to help her meet the required timescales and safeguarding actions. She was not Ms Seaward's supervisor.
- During their "on track chats", Ms Seaward had been able to demonstrate a clear understanding of what needed to be done and by when, she had been able to identify the safeguarding risks and suggest a sound plan for mitigation of those risks.
- Ms Buttar would follow up the "on track chats" with clear directions and expectations about next steps, time frames and what needed to be done by email.
- Despite the structured "on track chats" and clear directions, Ms Seaward's performance across all of the original areas of concern did not improve. Ms Buttar found that there was a disconnect between what Ms Seaward knew and what she was able to put into practice.

- Ms Buttar explained to the panel the case allocation system and how Ms Seaward would be aware of the cases she was responsible for.
- Ms Buttar gave the example of Service User J, which had been allocated to Ms Seaward on 11 May 2022 but had not adequately progressed the case by October 2022, despite being the subject of “on track chats”. As a result, the original safeguarding concerns raised by the school had not been addressed. When the case was reallocated to a new social worker, progress had been made quickly and a short-term placement had been found.
- Ms Buttar did not accept that Ms Seaward’s shortfalls in practice were limited to record keeping as there had been a myriad of concerns which meant Ms Seaward had been remiss in her duties which had impacted on the level of care received by service users.
- [PRIVATE]
- Ms Buttar believed that her role had been supportive and that Ms Seaward had received a lot of support from others in the team.

Lisa Rooney

29. Ms Lisa Rooney attended to give evidence and confirmed and adopted the contents of her witness statement dated 3 September 2025. In addition, she informed the panel that;

- She had been asked, in December 2022, to undertake an investigation into Ms Seaward’s work in relation to Service Users J & K. She also attended a disciplinary hearing to present her report and findings.
- She believed that Ms Seaward’s managers were trying to support her. [PRIVATE] [PRIVATE].
- Ms Rooney did consider whether Ms Seaward was undertaking the work but just failing to record the tasks undertaken, however, there was limited evidence to support Ms Seaward’s view that progress on cases was being made but not being recorded.
- Ms Rooney struggled to understand how there had been such a disconnect between the knowledge Ms Seaward had and her ability to put it into practice.
- Ms Rooney did not see any evidence that Ms Seaward was being treated differently or singled out. It appeared to her that Ms Seaward’s managers were being supportive and trying to help Ms Seaward achieve and complete her role successfully.

Ellen Nicholas

30. Ms Ellen Nicholas attended to give evidence and confirmed and adopted the contents of her witness statement dated 29 September 2025. In addition, she told the panel that;
- She had had the same role, tasks and responsibilities in the team as Ms Seaward at the relevant time. She had had a case load of about 16, in addition to her duty responsibilities.
 - The expectations for the team at the time was that contact had to be made with the Service User within 48 hours of allocation, unless you were on leave or unwell, in which case you had to note the delay in the care records.
 - She found everyone on the team to be really nice. There had been a working from home policy but you could be in the office if you chose to be or if you were on duty. She had no sense of anyone being treated unfairly or differently.

Amy Dundas

31. Ms Amy Dundas attended to give evidence and confirmed and adopted the contents of her witness statement dated 16 January 2026. In addition, she told the panel that;
- At the relevant time she had been the Ward Matron. She believed that the key to a successful working relationship between a hospital and social services is communication, especially in light of the budgeting issues both have.
 - Service User I had been fit to be discharged from hospital in February 2022 but was still there in June 2022 as a result of Ms Seaward's failure to progress the case.
 - In her role, she had come across cases in the past when a patient's discharge had been delayed by lack of progress from a social worker however, this was the most extreme example. In addition, there were serious safeguarding issues which were not being progressed.
 - Ms Dundas believed that that the delayed discharge was the direct result of Ms Seaward's performance issues. If Ms Seaward had progressed the case properly it is possible other issues may have arisen (for example the availability of suitable accommodation) but the case did not progress far enough to establish whether there were any other barriers to the Service User's discharge.

Cynthia Henry

32. Ms Cynthia Henry attended to give evidence. As detailed above, her statement was not relied upon by Social Work England but was provided in order to provide a full and balanced picture for the panel. Having considered Ms Henry's statement, the panel asked that she be called to give evidence. In addition to confirming and adopting the

contents of her witness statement dated 9 October 2025, Ms Henry stated in evidence that;

- She became Ms Seaward's supervisor in January or February 2021 having been asked to take over the role by the exiting Team Manager. She had little to no handover with the previous supervisor.
- She was aware that Ms Seaward had some personal and performance issues, as they had worked in the same team previously.
- [PRIVATE].
- Their supervision sessions were scheduled regularly, but perhaps did not take place as often as they should have. This was often caused by Ms Seaward being on leave or off sick. When the supervision sessions happened, they were productive and Ms Seaward would call her if she had an issue.
- She had been aware of some small issues with Ms Seaward's performance, which they had discussed, but was not aware of the bigger concerns until these were flagged to her by others.
- She believed that the possible barriers for Ms Seaward's performance might have included [PRIVATE], the lack of a team manager for 4-6 months and the number of changes in the team.
- [PRIVATE].
- Overall, she described the team at the time as happy and supportive.
- Looking back at the case notes for Service User I now, she accepted that there had been an inappropriate delay in progressing the case and the safeguarding concerns.

Michelle Wright

33. Ms Wright attended to give evidence. She confirmed and adopted the contents of her witness statement dated 16 January 2026. In addition, she informed the panel that;

- Ms Seaward did not provide her notebook during the investigation;
- Ms Seaward was given the opportunity to review her case records and prepare a response at a second investigation meeting, but did not provide any further information or comment;
- She believed that Ms Seaward was not always clear about her whereabouts during the working day;
- She could recall Ms Seaward shared that she used dragon software and other IT equipment;

- Ms Seaward was allowed to have a “slower start” in the morning but it was not always clear if she was in fact unwell and therefore not attending work on that day;
- [PRIVATE].

Finding and reasons on facts:

34. The panel considered all of the evidence presented during the hearing, including the live witness testimony and the large bundle of evidence in the form of witness statements and exhibits. The panel listened carefully to the submissions made by Ms Culleton on behalf of Social Work England and the written submissions including the document labelled “References for Closing” and an updated Schedule of Evidence and annotated statement of case. The panel also heard and accepted the advice from the legal adviser which included advice and guidance in relation to;
 - The burden and standard of proof;
 - The approach to be taken when assessing the credibility of a witness (*R (Dutta) v GMC* [2020] EWHC 1974 (Admin));
 - Ms Seaward’s good character in terms of credibility and propensity and the adverse inference which may be drawn from her non-attendance;
 - Cross admissibility, in considering if some matters are found proved may lend support to other allegations of a similar nature by demonstrating a propensity to act in a certain way. (*PSA v GMC & Garrard* [2025] EWHC 318);
 - Opinion evidence, offered by non-expert witnesses should be approached with caution but not necessarily excluded; and
 - Speculation should be avoided, in particular in relation to possible defences Ms Seaward could have put forward in any of the opportunities to respond to Social Work England or during the internal investigation;
35. The panel noted that within the exhibit bundle it had been provided with extensive contemporaneous documentation for each of the allegations. The panel was mindful of the legal advice in relation to the case of *R v Dutta*, that where possible contemporaneous documents should form the basis of its deliberations, rather than starting with an assessment of the credibility of the witnesses who had given evidence.
36. In relation to the evidence provided by the witnesses, the panel found that their evidence was consistent with each other and with the objectively verifiable evidence provided in the contemporaneous evidence. Where the witnesses had expressed an opinion or referred to conclusions or decisions made as part of the internal disciplinary process, the panel recognised that it should reach its own conclusions rather than deferring to the opinions of others.

37. The panel noted that many of the allegations relate to the timeliness of Ms Seaward's contact and visits with Service Users and therefore considered it necessary to begin its deliberations by establishing the Council's expectations and/or requirements from the team of social workers that Ms Seaward was part of and whether Social Work England had proved that Ms Seaward was made aware of these expectations.
38. The panel found that the professional witnesses had been able to independently confirm what the expectations within the team had been at the time. The panel also had sight of relevant documents (although some were undated) and was satisfied that the team's guidance and policies would have been known to the members of the team, including Ms Seaward. The panel noted that Ms Seaward had not raised any issue with the expected timeframes during her employer's investigation and disciplinary process. The panel accepted that the expected timeframes had been put in place to ensure that social workers within the team responded and progressed cases appropriately once they had been allocated. The panel therefore accepted that, for all new allocations Ms Seaward was expected to;
- Make initial contact within 48 hours of allocation. That could consist of a telephone call of introduction to the service user or a family member or another relevant third party and would be contact to gather information and progress the referral;
 - Visit the service user within a maximum of 10 working days;
 - Return telephone calls and correspondence from service users and service providers on the same day or the following day (unless a social worker was absent from work, in which case there was an expectation that a response be made within 24 hours of their return); and
 - Complete case records within 48 hours.
39. The panel accepted that in relation to safeguarding concerns, the expectation was that a social worker must complete the concern within 5 days and with a safeguarding enquiry, a meeting must be set up within 5-7 working days.
40. The panel also accepted that as part of the risk assessment following a new allocation, social workers were expected to complete a Conversation 1 (the initial information gathering) on average within 10 working days, and a Conversation 2 (a more in depth assessment) on average within 6 weeks to 2 months. The panel accepted that this provided a structured approach to ensure the relevant information was gathered and explored and the case was progressed in line with expected time frames.
41. In assessing whether Social Work England had proved that actions hadn't been undertaken, the panel accepted, as a starting point and in the absence of evidence from Ms Seaward, the premise that if an action was not recorded by the Social Worker it hadn't been done.

42. The panel considered the suggestion made by Ms Seaward at the latter stage of her employer's investigation, in that she had felt singled out and that people were waiting for her to fail. After considering all of the evidence, including the oral evidence given by her managers, supervisors and colleagues, the panel reached the conclusion that her team had been supportive and hoped that Ms Seaward would succeed. [PRIVATE].

Paragraph 1

With respect to Service User A, you:-

- a. *Upon allocation on 21 July 2021,*
 - i. *Failed to make timely contact/attempt contact with Service User A;*
 - ii. *Failed to undertake a visit to Service User A in a timely manner;*
 - b. *Failed to respond to telephone calls from Service User A's stepson on 23 and/or 26 and/or 29 July 2021, in a timely manner;*
 - c. *Failed to action and/or progress a safeguarding referral in respect of Service User A received on 2 August 2021 from East Midlands Ambulance Service.*
43. The panel considered the relevant evidence and in particular the audit report written and exhibited by Meriel White and Service User A's case records. The panel accepted that the Service User A was allocated to Ms Seaward on 21 July 2021 following a referral from Service User A's stepson and required an urgent assessment for community support. The panel noted from the case records that Service User A's stepson had called and left a message asking for an update and requesting that Ms Seaward call him back on 23 July 2021, 26 July 2021, 29 July 2021 and 10 August 2021. In addition, a safeguarding referral from the ambulance service was received on 2 August 2021.
44. The panel considered any comments Ms Seaward gave in relation to this case during her employer's investigation and noted that she is recorded within the notes of the investigatory meeting dated 22 October [sic] 2021 as stating that "*she could recall the name but no further information ... duty and other responsibilities may have been the reason of the delay of work being completed*". The panel found that the repeated calls from the Service User A's stepson was consistent with the Council's case that Ms Seaward had not contacted, visited the Service User, responded to his phone calls or progressed the case.
45. The panel found that despite the Council's expectations for social workers to make contact within the first 48 hours of allocation, the case records show that Ms Seaward did not attempt to make contact with the service user or his stepson until 11 August, 15

working days later. The panel found that by doing so Ms Seaward had failed to make or attempt to make timely contact with the Service User.

46. The panel found that despite the Council's expectation that social workers should visit service users within 10 working days of allocation, Ms Seaward had not visited Service User A by the time she was notified of his death on 25 August 2021, 25 working days later.
47. The panel found despite the Council's expectation that social workers respond to telephone calls on the same or following day, Ms Seaward failed to respond to the stepson's calls on 23, 26 & 29 July 2021 until 11 August 2021. The panel noted that Ms Seaward was on annual leave from 19-27 July 2021 (which encompassed the first two calls), but that the expectation was that she would respond to calls within 24 hours of her returning to work and she had failed to do so.
48. The panel considered the case records and could find no evidence that Ms Seaward had taken any steps to progress the safeguarding referral from the ambulance service on 2 August 2021 by the time she was notified of Service User A's death on 25 August 2021, 16 working days later. This was far outside the expected timeframe of 5 working days to complete a safeguarding referral.
49. The panel did not find that Ms Seaward's comments during her employer's investigation altered its assessment of the evidence, in that she did not deny that the case had been allocated to her, the professional expectations or the fact she had failed to meet those expectations.
50. The panel therefore found Paragraph 1a(i), a(ii), b & c proved.

Paragraph 2

With respect to Service User B, you:-

- a. *Following a number of referrals received from 7 – 19 July 2021, and upon allocation on 21 July 2021,*
 - i. *Failed to make timely contact/attempt contact with Service User B and/or the referrers;*
 - ii. *Failed to undertake a visit to Service User B in a timely manner;*
- b. *Further to 2 (a) above, failed to respond in a timely way to a phone call from the referrer on 25 August 2021;*
- c. *Failed to adequately action and/or progress the safeguarding referrals received in respect of Service User B.*

51. The panel considered the relevant evidence and in particular the case records for Service User B and the evidence of Meriel White. The panel found there was a referral on 7 July and a further safeguarding concern raised on 12 July 2021 which had been allocated to Ms Seaward on 21 July 2021. Despite the urgent nature of the case, no contact or visit with the service user was recorded before Ms Seaward was suspended on 8 September 2021, which was far outside the expected timeframes as set out above.
52. The panel found that the Service User B's case notes record a call from the referrer (an independent living officer) on 25 August 2021. There is no record that Ms Seaward responded to this telephone call at all before her suspension 10 working days later. This was despite the team's clear expectation that calls be returned within 48 hours.
53. The panel found that there were no recorded actions by Ms Seaward including undertaking visits, within the case notes or referred to elsewhere, from the date of allocation on 21 July 2021 to her suspension on 8 September 2021. As a result, the panel there found that Ms Seaward had failed to adequately action or progress the safeguarding referral received on 12 July 2021.
54. The panel considered Ms Seaward's comments during her employer's investigation in relation to this case in that she "*could not comment or elaborate on the case*". The panel did not find that Ms Seaward's comments altered its assessment of the evidence, for the reasons set out above.
55. The panel therefore found Paragraph 2(a)(i), (a)(ii), (b) and (c) proved.

Paragraph 3

With respect to Service User C, you:-

- a. *Following allocation on or around 28 June 2021,*
 - i. *Failed to make timely contact/attempt contact with Service User C;*
 - ii. *Failed to undertake a visit to Service User C in a timely manner;*
 - b. *Further to 3 (a) above, between 15 July 2021 and 25 August 2021, failed to follow up, and/or to record any follow up, to seek to establish contact with Service User C, in order to enable her care package to be reassessed.*
56. The panel noted that Ms Seaward had been allocated this case on 28 June 2021 in order to carry out a review of the Service User's community care package. The panel noted that the case notes record an attempt to contact the Service User on 15 July 2021 (28 working days later) but that there was no answer. There was no record of any other action by Ms Seaward to progress this case before her suspension in September 2021.

The panel considered that the single attempt at contact was far outside the required timeframe to contact a service user within 48 hours of allocation and the referral should have been followed up.

57. The panel considered Ms Seaward's comments during her employer's investigation, that she "could recall [the case] and advised that she had worked on this case on duty, dealt with phone calls and recognised that it needed to be allocated." The panel found that it was likely that Ms Seaward had been allocated the case on 28 June 2021 as she had had an On Track Chat about the case with her manager in which they discussed the necessary actions on 25 August 2021 and that she therefore had responsibility for progressing the reassessment of Service User C's community care package, but failed to do so.
58. The panel therefore found Paragraph 3(a)(i), (a)(ii) and (b) proved.

Paragraph 4

With respect to Service User D, you:-

- a. Following allocation on 23 June 2021,*
 - i. Failed to make timely contact/attempted contact with Service User D;*
 - ii. Failed to undertake a visit to Service User D in a timely manner;*
 - b. Following 15 July 2021 having called Service User D an ambulance at his request during a telephone call with you, did not follow up with Service User D and/or the hospital.*
59. The panel accepted the evidence from Ms Meriel White, that Ms Seaward had been allocated this case on 23 June 2021 and that she should have contacted Service User D within 48 hours. The panel found that Ms Seaward, as evidenced in the case notes, did not contact the Service User until 15 July 2021 (16 working days later) and made no attempt to visit before her suspension in September 2021.
60. The panel noted within the case records that on 15 July 2021 during a telephone call Service User D had been incoherent and had repeatedly asked Ms Seaward to call an ambulance due to chest pain. The case note stated that Ms Seaward had called an ambulance and she was informed that one would be sent to him when it was next available. The panel noted that there was no record of any follow up call to Service User D, the hospital or any third party. This was despite a clear reminder from Ms Seaward's manager during an On Track Chat on 25 August 2021, to ring or visit the Service User.
61. The panel considered Ms Seaward's response to her employer during the internal investigation, in that "*the name was known but she could not recall anything further*".

62. The panel therefore found Paragraph 4(a)(i), (a)(ii) and (b) proved.

Paragraph 5

With respect to Service User E, you:-

a. Following allocation on 14 June 2021:-

i. Failed to make timely contact/attempt contact with Service User E;

ii. Failed to undertake a visit to Service User E in a timely manner;

b. As a result of 5(a) above, failed to take appropriate action in relation to safeguarding concerns in a timely manner or at all.

63. The panel accepted the evidence from Ms Meriel White, that Ms Seaward had been allocated the case of Service User E on 14 June 2021, following a safeguarding referral about domestic violence concerns, mental health and financial management, and that she should have contacted her within 48 hours. The panel considered the case records and noted that Ms Seaward did not attempt to contact the Service User until 15 July 2021 (24 working days later) and did undertake a visit before her suspension in September 2021.

64. The panel could find no evidence within the case records that Ms Seaward had taken any action in relation to the safeguarding concerns. The panel considered Ms Seaward's response to her employer during the internal investigation, in that she believed she had texted her the week prior to being suspended but could not justify the delay. She said there had been other priorities on her time including duty and hospital work. The panel considered that even if Ms Seaward had texted Service User E in September 2021 this was far outside the expected timeframes and insufficient to meet the requirement to make contact.

65. The panel found that there was no evidence that Ms Seaward had taken appropriate action in relation to the safeguarding concern.

66. The panel therefore found Paragraph 5(a)(i), (a)(ii) and (b) proved.

Paragraph 6

With respect to Service User F, you:-

a. Following allocation on 9 June 2021,

i. Failed to make timely contact/attempt contact with Service User F;

ii. Failed to undertake a visit to Service User F in a timely manner;

b. Between 15 July 2021 and 6 August 2021, failed to adequately consider and assess Service User F's needs.

67. The panel accepted the evidence of Meriel White in that the case had been allocated to Ms Seaward on 9 June 2021 to undertake an assessment of her community care package and that she should have contacted the Service User within 48 hours. The panel noted that the case records show that Ms Seaward first attempted to contact Service User F on 15 July 2021 (27 working days later). The panel found that there was no record of Ms Seaward visiting Service User F before her suspension in September 2021.
68. The panel considered Ms Seaward's response to her employer during the internal investigation, in that she could recall the case and believed it had been closed and assigned to the hospital team. The panel could find no evidence to support the suggestion that the case had been closed or transferred to a different team and therefore determined that Service User F remained Ms Seaward's responsibility.
69. The panel found that there was no evidence that Ms Seaward had make any attempt to consider or assess Service User F's needs.
70. The panel therefore found Paragraph 6(a)(i), (a)(ii) and (b) proved.

Paragraph 7

With respect to Service User G, you:-

- a. Failed to attend and/or record attendance at arranged visits to Service User G on 22 June 2021 and/or 20 July 2021;*
- b. Failed to make and/or record any contact with Service User G and/or their family between 11 August 2021 and 7 September 2021;*
- c. Following voicemail messages from Service User G's family on 7 and/or 9 September 2021, did not respond in a timely manner or at all;*
- d. As a result of any or all of 7 (a) – 7 (c), failed to adequately consider and assess Service User G's needs;*
- e. Failed to complete a Care Act Assessment.*

71. The panel accepted the evidence of Meriel White that Ms Seaward had been allocated the case of Service User G on 9 June 2021 to consider whether her husband was able to care for her sufficiently and to undertake a financial assessment under the Care Act. The panel noted that Mr Seaward made contact by telephone on 11 June 2021 and arranged a home visit on 16 June 2021. The panel found that the case note made

following the visit on 16 June 2021 stated that a follow-up visit had been arranged on 22 June 2021. The panel considered the case records and found that there was no evidence or record of the visit on 22 June 2021 taking place.

72. The panel noted that the case record showed that a new visit was arranged during a telephone call on 14 July 2021 to take place on 20 July 2021. However, there is no corresponding record of any visit taking place on 20 July 2021.
73. The panel therefore found Paragraph 7(a) proved.
74. The panel considered the case records and found that there was no evidence that Ms Seaward made any contact with Service User G or her family between 11 August 2021 and 7 September 2021. The panel noted that the witness statement of Service User F's daughter, Valerie Goryll suggested that the family had met Ms Seaward 2 or 3 times but is only clear about the visit on 16 June 2021. The panel also noted that during this time the family called the Council on a number of occasions to chase for an update. The panel therefore considered that on the balance of probabilities Ms Seaward did not make contact between 11 August and 7 September and in any event, did not record any contact during the same period.
75. The panel therefore found Paragraph 7(b) proved.
76. The panel noted that Service User G's family left messages with the Community Hub on 7th and 9 September 2021 but that there is no record of Ms Seaward returning the calls. The panel noted that Ms Seaward was in a disciplinary meeting on 7 September, received a letter notifying her that she was suspended from work on 8 September and that the suspension took effect on 9 September 2021. The panel found that there was evidence Ms Seaward was at work on 8 September and that the expectation was that social workers return such telephone calls on the same day or the following day.
77. The panel therefore found Paragraph 7(c) proved in respect of the call on 7 September but not in relation to the call on 9th September as she had been suspended on that date.
78. The panel considered the overall effectiveness of Ms Seaward's handling of this case. The panel noted that she had completed a telephone call and visit shortly after the allocation of the case which evidenced that she was starting to consider Service User G's needs. However, the case records show that the family were informing social services of escalating changes to Service User G's circumstances over the relevant period which would have necessitated further consideration. Ms Seaward did not visit or progress the case after the early visit. Therefore, although there was some evidence that Ms Seaward had started her assessment of Service User G's needs, the panel found that this was not adequate.
79. The panel therefore found Paragraph 7(d) proved.
80. The panel found no evidence that Ms Seaward had completed the financial assessment (which is part of the Care Act Assessment) by the time of her suspension in September

2021, despite having been specifically tasked to do so. The panel noted that Ms Seaward had told her employer during the internal investigation that she had completed most of the care plan (also part of the Care Act Assessment) but that the document may not have been on the computer system. The panel noted that Ms Seaward was afforded time after the first investigation meeting to check her records and provide any paper files, notes or documents which were not recorded on the system. The panel noted that Ms Seaward failed to provide any further evidence at the next meeting. In any event, the panel noted that Ms Seaward accepted she had not completed the care plan (required part of the Care Act Assessment) by the time of her suspension, over two months after the case had been allocated to her.

81. The panel therefore found Paragraph 7 (e) proved.

82. In summary the Panel found Paragraph 7(a), (b), (c) in part, (d), and (e) proved.

Paragraph 8

With respect to Service User H, you:-

- a. Following referrals received on 20 and 21 July 2021, failed to make timely contact/attempt contact with the referrer and/or Service User H;*
- b. As a result of 8(a) above, failed to adequately consider and assess Service User H's needs and/or caused a delay to Service User H receiving community support;*
- c. From around 18 August 2021 when Service User H was ready to be discharged from hospital, failed to adequately follow up and/or action necessary next steps, including:-*
 - i. Advising on referring for a telephone lifeline;*
 - ii. Completing an assessment for a community care package;*
- d. Failed to adequately action and/or progress the safeguarding referrals received in respect of Service User H.*

83. The panel accepted the evidence of Meriel White that Service User H had been allocated to Ms Seaward since February 2021 and noted that it was not being asked to consider any issues in relation to her handling of the case until July 2021 (5 months after allocation). During this time there appears to have been a deterioration in Service User H's health which culminated in two referrals from East Midlands Ambulance Service which were received on 20 and 21 July 2021. The panel had sight of both referrals and noted that they indicated that Service User H might need formal care following issues of self-neglect. The panel also noted that the case records state that the referrals were sent/emailed to the allocated social worker.

84. The panel found that there was no record of any attempt to make contact with the referrers, the Service User or any relevant third party until Ms Seaward contacted the homecare provider on 11 August 2021 (14 working days after the second referral) despite the expectation that contact be made on the same or following day.
85. The panel found that this did not amount to timely contact and therefore found Paragraph 8 (a) proved.
86. The panel found that having failed to make any contact for 14 working days after the two referrals, Ms Seaward delayed in her consideration and assessment of Service User H's needs and likely caused a delay in her establishing the necessary community support to enable her discharge from hospital.
87. The panel therefore found Paragraph 8 (b) proved.
88. The panel inferred from Ms White's evidence that once a service user is identified as being unable to meet their own needs that the allocated social worker should undertake a care assessment. The panel found that this requirement was fundamental to an adult social care role. As per the Ambulance Service referral it was clearly identified that Service User H had no one to help him so the care assessment should have been completed as a priority. The panel also found that Ms Seaward had been told to complete the community care package assessment at an On Track Chat with her supervisor on 25 August 2021.
89. The panel found that Ms Seaward's case note dated 11 August 2021 records that the hospital has assessed Service User H as medically fit for discharge. This was followed up with an email to Ms Seaward from the Dementia Team on 18 August 2021, following a home visit in which they requested a social care responder for a Lifeline.
90. Following this development the panel found that the records show Ms Seaward had a conversation with the Dementia Team on 31 August 2021 during which she was reminded that the hospital would not discharge Service User H until the Lifeline had been installed. Ms Seaward agreed to make the relevant referral.
91. Although no specific entry was recorded documenting when Service User H was discharged, it is clear from the telephone record on 6 September 2021 that Service User H is now at home. There is no record of Ms Seaward advising on the Lifeline at all and in any event had clearly not done so by 31 August despite the initial request on 18 August 2021.
92. The panel found that there is no evidence that Ms Seaward completed a community care package before her suspension on 8 September 2021. This is supported by the email to Ms Seaward dated 8 September 2021 in which she is chased by the Principal Social Worker for her assessment as the current interim package is only limited to 4 weeks.
93. The panel therefore found Paragraph (c)(i) and (ii) proved.

94. The panel considered that the lack of progress detailed above amounts to a failure by Ms Seaward to act on the safeguarding referrals on 20 and 21 July 2021. The panel therefore found Paragraph (d) proved.
95. At each stage, the panel considered Ms Seaward's account during her employer's investigation in that she could recall the Service User's name but was unable to justify the delay in recording. She believed that work had been done but that the notes were missing from the system. The panel found that Ms Seaward had been given an opportunity to provide any notes or documents she had which were not on the system at the second interview but did not do so. The panel therefore found that it was more likely than not that the case records were an accurate reflection of the work undertaken.
96. In summary the panel found Paragraph 8(a), (b), (c)(i), (c)(ii) and (d) proved.

Paragraph 9

With respect to Service User I, you:-

- a. Following allocation on 19 January 2021,*

 - i. Failed to make timely contact/attempted contact with Service User I and or/the referrer;*
 - ii. Failed to undertake a visit to Service User I in a timely manner;*

- b. Following carrying out an assessment of Service User I on 18 February 2021, failed to*
 - i. Make contact with Service User I's family in a timely way;*
 - ii. Complete the assessment;*
 - iii. Respond to an email from one of Service User I's sons complaining about lack of contact and involvement;*
- c. Following a safeguarding concern being raised on 16 March 2021, did not take any, or any adequate action, in a timely way, to gather information and/or assess risk and/or commence a Care Act Assessment;*
- d. Following concerns being raised by the hospital on 29 April 2021, did not take any action or any adequate action;*
- e. Following a further safeguarding concern being raised on 7 May 2021, did not take any action or any adequate action;*

- f. Failed to respond to the hospital's requests for updates on 3 and/or 8 June 2021 in a timely way, or at all;*
- g. Between 23 June 2021 and 9 July 2021 failed to follow up or review the case;*
- h. Failed to attend, or failed to record attendance at, a visit to Service User I on 12 July 2021.*

97. The panel accepted the evidence of Ms Meriel White that Service User I had been allocated to Ms Seaward on 19 January 2021, to explore her needs and contribute to discharge planning and support. The panel found that Ms Seaward would have been expected to make contact with Service User I within 48 hours of allocation. The panel found that the case records show that Ms Seaward contacted the hospital on 29 January 2021 (8 working days later) and did not visit to the Service User until 18 February 2021 (25 working days later). The panel noted that the expectation was for Ms Seaward to undertake a visit within 10 working days. The panel took into account the fact that a number of visits had been arranged in advance of this date but that there were insufficient reasons given for these not taking place. The panel also took into account the fact that Ms Seaward appeared to have been on annual leave from 2 February until 15 February. The panel did not consider that this sufficiently justified the delays.
98. The panel therefore found Paragraph (a)(i) and (a)(ii) proved.
99. The panel noted that Ms Seaward recorded in the case notes following the visit on 18 February 2021 that she would type the assessment up and contact the family to include their views. The panel found that there is no record of any contact with Service User I's family until 10 March 2021 and no record of the assessment being completed. Given the urgency of the situation the panel did not find this contact to be "timely".
100. The panel therefore found Paragraph (b)(i) and (b)(ii) proved.
101. The panel noted that the case records show that Service User I's son emailed Ms Seaward on 15 March 2021, raising a concern about the "*lack of contact and involvement in exploring [Service User I's] possible support*". Ms Seaward would have been expected to respond to this email within 48 hours. The panel found that there is no evidence Ms Seaward ever responded.
102. The panel therefore found Paragraph (b)(iii) proved.
103. The panel found that, in response to the safeguarding referral received from the hospital on 16 March 2021 in respect of concerns about Service User I's welfare and possible mistreatment by sons, Ms Seaward contacted the hospital and Service User I's son on the 17 March 2021, to begin to gather further information. However, the panel found that there was no evidence Ms Seaward acted on the information to start a care act assessment. The next recorded action/contact made by Ms Seaward was not until 29 April 2021. The panel found that the expectation was that a safeguarding concern

must be completed within 5 working days. There was no evidence that Ms Seaward commenced the care act assessment.

104. The panel therefore found Paragraph (c) proved.
105. Although there is a record of discussions about this case during On Track Chats and conversations with a DOLS mental health assessor, the panel found that there was no evidence Ms Seaward took proactive steps, prior to her suspension in September 2021, following the additional concerns raised by the hospital on 29 April 2021.
106. The panel therefore found Paragraph (d) proved in part in that there was some action but not adequate action.
107. The panel found that there was no evidence Ms Seaward took any direct action (other than discussions noted above and a conversation with the hospital on 24 May 2021), prior to her suspension in September 2021, in response to a further safeguarding referral from the hospital on 7 May 2021 which explained that Service User I's son appeared to be living in the patient's home without her consent. The panel noted Ms Dundas's evidence that this additional referral had been necessary as there had been no response or action following the hospital's earlier referrals and contact with Ms Seaward.
108. The panel therefore found Paragraph (e) proved.
109. The panel found that there was no evidence Ms Seaward, prior to her suspension in September 2021, responded to emails the hospital sent on 3 and 8 June which had been sent due to the continued lack of response from Ms Seaward and the failure to progress any plan or placement to facilitate Service User I's discharge from hospital. The panel noted that Ms Seaward was expected to respond to such emails within 48 hours.
110. The panel therefore found Paragraph (f) proved.
111. The panel found that there was no evidence of any contact or actions undertaken by Ms Seaward in relation to following up or reviewing the case of Service User I, between 23 June and 9 July 2021. This was despite the outstanding safeguarding concerns and the fact that she was medically fit for discharge from the acute ward at the hospital.
112. The panel therefore found Paragraph (g) proved.
113. The panel noted that within a record of a telephone call on 9 July 2021, Ms Seaward has recorded that a visit to Service User I was agreed for 12 July at 2pm. The next recording within the case notes is an On Track Chat on 25 August 2021. The panel therefore found that Ms Seaward either failed to attend or failed to record her attendance on 12 July 2021. The panel note that the expectation was that records be completed within 48 hours.
114. The panel therefore found Paragraph (h) proved.

115. When reaching its decisions the panel took into account Ms Seaward's response at the internal investigation that;

“this was a complex case, an older person who had dementia. There was a lot of meetings internally and externally due to concerns of no power of attorney. Amanda shared that she was not confident with this particular case as she has not had much experience with older people and dementia. Amanda mentioned that she did ask Cynthia to visit Beryl with her but she did not attend. Work was ongoing, Meriel mentioned the case on the Thursday Amanda was suspended. No documentation or plan.”

116. The panel found that although there were complexities in the case, this did not provide sufficient reason for the extent of the delays in progressing the case or responded to safeguarding concerns and correspondence. The panel accepted the evidence of the professional witnesses, that Ms Seaward was an experienced social worker who had been provided with and had access to additional training if needed. The panel found that the issues raised in this case relate to core social work skills rather than specific specialist knowledge.

117. In summary the panel found Paragraph 9 (a), (b), (c), (d) in part, (e), (f), (g) and (h) proved.

Paragraph 10

With respect to Service User J, you:-

- a. Between around 11 May 2022 and 13 November 2022 did not make and/or record adequate progress on the case;*
- b. On or around 17 October 2022, took possession of Service User J's mobile phone;*
- c. On or around 17 October 2022, made no record of having taken possession of Service User J's mobile phone or the reasons for having done so;*
- d. Following information received from Service User J's father on 17 October 2022, did not follow up with other relevant parties/bodies (Service User J's college and the police), in a timely way;*
- e. As a result of any or all of 10 (a) – (d) above, failed to take appropriate action in relation to safeguarding concerns.*

118. The panel was mindful of the fact that Ms Seaward was allocated the case of Service User J on 11 May 2022, after her return to work following her suspension. The panel was also mindful that following her return, Ms Seaward had been supported by Ms Lisa

Buttar, who undertook regular On Track Chat discussions and often provided follow up emails with specific instructions on expected next steps.

119. The panel noted that Ms Seaward made 36 entries within the case records during the relevant time period which suggested that she was heavily involved in the case, particularly in relation to his homelessness. However, there were significant gaps in activity between 8 July and 17 October 2022.
120. The panel accepted the evidence from Ms Meriel White and Lisa Buttar, that the process Ms Seaward was expected to follow to ensure adequate progress in this case was the completion of a “Conversation 1” and a “Conversation 2”. The panel found that despite numerous reminders from Ms Buttar during their On Track Chats, Ms Seaward failed to complete these stages of her assessment within the expected timeframes. The Conversation 1 was completed on file on 11 September 2022 (4 months later) despite the expectation that this stage be completed within an average of 10 days. The panel noted that the Conversation 2 documentation was never started. The panel therefore found that despite case notes referencing emails and phone calls on the file evidencing her involvement, she failed to make and/or record adequate progress in this case between 11 May 2022 and 13 November 2022.
121. The panel therefore found Paragraph (a) proved.
122. The panel was satisfied that Ms Seaward did take possession of Service User J’s phone on or around 17 October 2022. The panel noted that Ms Seaward had admitted to doing so during her employer’s investigation.
123. The panel therefore found Paragraph (b) proved.
124. The panel carefully considered the relevant case records and noted that Ms Seaward had recorded the fact that Service User J’s father had informed her he had taken the phone and then at a later date, that she had picked up clothes, toiletries and a college bag for the Service User. The panel found, that although there is reference to Ms Seaward collecting some of the Service User’s personal items she did not specifically reference the mobile phone. Nor did she reference her reason for having taken the phone due to the concern about inappropriate messages and the possible police involvement. The panel found that Ms Seaward should have known this was key information to provide on the case file.
125. The panel therefore found Paragraph (c) proved.
126. The panel found that following Ms Seaward’s conversation with Service J’s father on 17 October 2022, in which he disclosed that he had reported the telephone messages to the police, Ms Seaward received a telephone call from Service User J’s college on 31 October (10 working days later) requesting an update. Ms Seaward told the college she had not looked at the telephone messages yet. Ms Seaward contacted the police on 1 November 2022 (11 working days later) to request an update and was informed that the crime was “cancelled”. The panel found that given the serious safeguarding concerns which arise from potentially inappropriate messages being sent by a vulnerable man to

a 14 year old girl, Ms Seaward should have acted with far more urgency on this issue and that she did not follow up with the college or the police in a timely way.

127. The panel therefore found Paragraph (d) proved.
128. As detailed above, the panel considered that the disclosure from Service User J's father that potentially inappropriate messages had been sent to a 14 year old girl was a serious safeguarding concern. The panel found that by failing to record the fact that she had the phone, failing to look at the messages in a timely way or pass the phone to the police, failing to collate the information and failing to liaise with the other professionals in a timely way, Ms Seaward had failed to take appropriate action. The panel also found that it was likely that by failing to progress the Conversation 1 and 2, Ms Seaward would have missed important information and therefore failed to safeguard the Service User.
129. The panel therefore found Paragraph (e) proved.
130. In reaching its conclusions above, the panel took into account Ms Seaward's comments during her employer's investigation in that she initially sought to justify taking the phone but ultimately recognised that it wasn't the correct thing to do.

Paragraph 11

With respect to Service User K, you:-

- a. Following a failed visit to Service User K on 4 November 2022 did not adequately follow up and/or liaise with other relevant parties;*
- b. Failed to adequately complete the safeguarding concern that had been raised.*

131. The panel noted that in relation to Service User K, Ms Seaward had acted in her capacity as the duty social worker and had not been allocated the case. The panel was mindful of this in assessing what Ms Seaward's professional responsibilities were in relation to this case.
132. The panel took into account Ms Seaward's response during her employer's investigation including that she agreed to undertake the duty visit on 4 November 2022 as the team were struggling to cover it but that she had been unable to gain entry. She said that the referral had been received by the team on 31 October and that the severity/urgency of the concern had not been recognised by any other colleagues. Ms Seaward said that with hindsight she should have contacted the referrer on the same day but had handed this over for the duty team on the following Monday. Overall, Ms Seaward believed she acted reasonably.
133. The panel found that, given the serious nature of the safeguarding concern, on return from the failed visit to Service User K, Ms Seaward should have used her professional judgment to recognise the need to communicate the fact of the failed visit to the referrer and/or the police or the necessity of attempting to repeat the visit on the same day. The panel noted that the case records show that Ms Seaward communicated the

information to the principal duty social worker, who also had responsibility for this case, but that this was insufficient given the circumstances.

134. The panel therefore found Paragraph (a) proved.
135. The panel noted that Ms Seaward was involved in this case as a duty social worker on 4 November 2022 and that in this role she did not take all the steps expected of her on the day. However, she was not the allocated social worker in the case and therefore was not responsible for the overall completion of the safeguarding concern as per the guidelines that this work should be completed within 5 working days.
136. The panel therefore found Paragraph (b) not proved.

Paragraph 12

With respect to Service User L, you:-

- a. Following a telephone call from Service User L's son on 10 June 2022, failed to communicate with him and/or other service providers in a timely way;*
 - b. Failed to maintain adequate communications with Service User L's family between 8 and 29 July 2022 and/or update the records to record any communications that there had been in that time period;*
 - c. Between 24 August and 3 November 2022, failed to adequately progress the actions required including:-*
 - i. Addressing/raising the Safeguarding and Notification of Concern that had been raised;*
 - ii. Following up with the care provider;*
 - iii. Discussions with Service User L's son;*
 - iv. Discussion with Service User L.*
 - d. Failed to adequately record contact with Service User L's son.*
137. The panel found that the case of Service User L was allocated to Ms Seaward on 14 April 2022 following a referral from the ambulance service with concerns over her wellbeing and self-neglect.
 138. The panel noted that Ms Seaward did not provide any comments in relation to this matter during her employer's investigation.
 139. The panel considered the case notes and found that on 10 June 2022, Ms Seaward made a record on the case file that she had received a telephone call from Service User L's son who advised that his mum was getting worse, had recently been in hospital but had been discharged. Ms Seaward recorded that she had told the son she would "look

at [Service User L]’s records and see where it is at and see if [she] can chase brokerage”. The son phoned the emergency duty team on 19 June as he had not received an update. The panel noted that Ms Seaward did not record any action until 22 June when she asked Ms Henry to contact brokerage on her behalf. Ms Seaward called Service User L’s son back on 23 June 2022 (8 working days after the initial call).

140. The panel found, that in light of the information about Service User L’s changing circumstances, the delay in communicating with the son or other service providers to organise additional care, following the conversation on 10 June 2022, was inappropriate.
141. The panel therefore found paragraph (a) proved.
142. The panel found that after recording a telephone conversation with Service User L’s son on 8 July 2022, Ms Seaward did not record any further communication with Service User L’s family until a text message on 29 July 2022.
143. The panel therefore found paragraph (b) proved.
144. The panel noted that according to the case records, following a home visit on 23 August 2022, the next entry by Ms Seaward was made on 13 October 2022, when she recorded that a voicemail message had been left by Service User L’s son on 5 October but that this had not been picked up due to her absence from work. Ms Seaward spoke to the son at length on the 13th October 2022 and submitted a safeguarding concern form on 14th October 2022. The case notes document further actions regarding the safeguarding concern, attempts to follow up with the care provider and communication with the son from the 14th October to 3rd November 2022.
145. The panel therefore found Paragraph (c) and (d) not proved.
146. In summary, the panel found Paragraph 12 (a) and (b) proved, but found (c) and (d) not proved.

Paragraph 13

With respect to Service User M, you:-

- a. Between around 27 April 2022 and 9 October 2022, failed to adequately progress the case in a timely way, and/or record actions taken to progress the case in a timely way including in respect of:-*
 - i. Carrying out a visit to Service User M on 4 May 2022;*
 - ii. Scheduling multi-disciplinary team meetings;*
 - iii. From around 23 June 2022, progressing agreed actions to follow up with the GP and/or environmental health and/or the RSPCA and/or the police;*

iv. From around 23 June 2022, addressing the safeguarding concern that had been raised.

147. The panel found that Service User M was allocated to Ms Seaward on 22 April 2022, following discharge from hospital for listeria and was reported to have poor living conditions at home.
148. The panel noted a case note added by Ms Seaward on 4 May 2022, in which during a phone call she states that she had arranged to visit Service User M that day. The panel found that there was no recording to indicate whether or not that visit took place.
149. The panel therefore found Paragraph (a)(i) proved.
150. The panel noted that the records state that during an On Track Chat on 11 May 2022, Ms Seaward was tasked with scheduling the next multi-disciplinary meeting on 19 June 2022 and set actions to call Environmental Health and the Service User's daughter. The panel also noted that on 19 June 2022, Service User M's GP practice emailed to say the doctor could not attend the meeting due to receiving the teams invite "last night". As a result, the meeting did not go ahead. The panel found, that although Ms Seaward appears to have arranged the meeting, she did not send the invites out in a timely manner which meant the meeting could not go ahead due to the unavailability of professionals.
151. Ms Seaward was asked to rearrange the meeting for 28 June 2022, which took place as arranged. There is no record of a meeting taking place in July or August and the panel found that the meeting arranged for 20 September 2022 was cancelled as Ms Seaward was unwell. The On Track Chat dated 12 October 2022 states that "*the MDT had to be cancelled in your absence as no updates on system*". The panel therefore found that there was a failure to adequately progress the case by scheduling effective multi-disciplinary team meetings.
152. The panel therefore found Paragraph (a)(ii) proved.
153. The panel found that Ms Seaward had agreed during an On Track Chat on 22 June 2022 to get an update from Environmental Health in advance of the multi-disciplinary team meeting on 28 June 2022, but there is no record of Ms Seaward doing so. The panel found that Ms Seaward had agreed during an On Track Chat 29 June 2022, to ensure that her discussion with Service User M's GP was recorded in the case notes. The panel could find no record of this being actioned. The panel could find no specific record after 23 June 2022 that Ms Seaward agreed actions to follow up with the RSPCA and/or the police.
154. The panel therefore found Paragraph a(iii) proved in part, in relation to Environmental Health and the GP but not in relation to the RSPCA or the police.
155. The panel found that there were no actions on the file from 24 June to the 29 July 2022. The panel took into account the fact that Ms Seaward appears to have been on annual leave for 5 days during this period. Despite this, the panel found that failing to take any

action during this period in relation to a safeguarding concern meant that Ms Seaward was failing to adequately progress the case in a timely manner. The panel noted that the expectation was that safeguarding concerns be concluded within 5 working days.

156. The panel therefore found paragraph (a)(iv) proved.

157. In summary the panel found paragraph (a)(i), (ii), (iii) in part and (iv) proved.

Paragraph 14

With respect to Service User N, you:-

- a. Following allocation to Service User N on 4 May 2022,*
 - i. Failed to make timely contact/attempted contact with Service User N;*
 - ii. Failed to arrange and/or undertake a visit to Service User N in a timely manner.*
- b. Following visiting Service User N on 30 May 2022, you failed to adequately progress the matter in a timely way and/or adequately complete the records and required documentation including in respect of:-*
 - i. Initial contact/conversation 1 paperwork;*
 - ii. Follow up with Service User N;*
 - iii. Follow up with the housing application.*

158. The panel found that Ms Seaward had been allocated the case of Service User N on 4 May 2022, following a referral on 1 May 2022 due to concerns relating to self-neglect. During an On Track Chat on 11 May 2022 (5 working days later) it was noted that Ms Seaward had not made contact with Service User N, despite the expectation that she make contact within 48 hours of allocation. The panel noted that the case records show that Ms Seaward attempted to contact Service User N on 11 May 2022, but there was no reply so she left a message. The panel noted that Ms Seaward first made contact with Service User N on 20 May 2022, 12 working days later.

159. The panel therefore found Paragraph (a)(i) proved.

160. The panel found that Ms Seaward first visited Service User N on 30 May 2022 (18 working days later) when the expectation was that a first visit take place within 10 working days.

161. The panel therefore found Paragraph (a)(ii) proved.

162. Following a visit on 30 May 2022, a number of tasks were agreed during On Track Chats with Ms Buttar, including;

- a reminder on 23 June 2022 to complete the initial contact information (which was not completed until 7 July 2022);
- to follow up with Service User N by 24 June 2022 (this was not done until 30 June 2022 when a voicemail only was left); and
- to complete the housing application by 24 June (which was not completed until 8 July 2022).

163. The panel therefore found Paragraph (b)(i)-(iii) proved.

Paragraph 15

With respect to Service User O, you:-

a. Between 30 May and November 2022, you did not adequately progress the matter, including in respect of:

- i. Conversation 1 and 2;*
- ii. Transfer to the 'Inclusion Team' (P2P);*
- iii. Speaking to Service User O and/or recording having spoken to Service User O;*
- iv. Adult Risk Management meetings and/or paperwork.*

164. The panel found that Ms Seaward had been allocated the case on 5 May 2022, following an initial referral on 10 April. During On Track Chats with Ms Buttar on 11 May 2022 and 30 May 2022, Ms Seaward was reminded of the need for timely contact, visits and case progression. In particular, in relation to Service User O, she was reminded to complete the Conversation 1 and 2, progress the transfer to the inclusion team (P2P) and progress the Adult Risk Management meeting. The same issues were raised at the On Track Meeting with Ms Buttar on 23 June 2022, because progress had not been made. The Adult Risk Management meeting took place on 22 July 2022 (over 10 weeks after allocation).

165. The panel accepted that the case records show Ms Seaward continued to meet with Service User O during this time, but there is no evidence of the specific tasks being completed despite a high level of supervision and guidance from Ms Buttar. The panel found that the tasks agreed during the On Track Chats were necessary to adequately progress the matter.

166. The panel therefore found Paragraph 15(a)(i)-(iv) proved in its entirety.

Paragraph 16

Your conduct at any or all of paragraphs 1 to 15 failed to safeguard the service users set out therein.

167. As part of the panel’s detailed deliberations on each of the Allegation’s sub paragraphs, as detailed above, the panel noted that Service Users A-O were each vulnerable and required the timely support of social services in order to safeguard them from harm. The tasks assigned to Ms Seaward, implicitly by guidance and policy and explicitly during supervision and On Track Chats, were required in order to ensure that the Service Users were adequately safeguarded.
168. For each of the Service Users, Ms Seaward failed in a myriad of ways to complete the tasks expected of her, despite numerous prompts and reminders. These failures included extensive delays in contact, visits, communication and the completion of key assessments.
169. The panel found that Ms Seaward’s management of the cases considered in detail above, left service users at risk of harm by not receiving the appropriate assessed support which was needed in a timely manner.
170. The panel therefore found Paragraph 16 proved.

Finding and reasons on grounds:

171. The panel heard and carefully considered the submissions on lack of competence made by Ms Culleton on behalf of Social Work England. The panel accepted the advice of the legal adviser which included;
- The relevant case law on the definition of lack of competence (*Calhaem v General Medical Council* [2007] EWHC 2601) in that it “*connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the {social worker’s} work*”;
 - A lack of competence is considered when performance drops below what could be expected of a reasonable peer in the same role (*Holton v General Medical Council* [2006] EWHC 2960); and
 - Social Work England’s Impairment and Sanctions Guidance paragraphs 153-155.
172. The panel determined that the allegations found proved were in relation to 14 cases which had been allocated to Ms Seaward and one case which she had worked on as a duty social worker. The panel took into account the evidence it heard that Ms Seaward’s average case load at the relevant time had been approximately 18 cases and found that over the two year period, this would amount to a “fair sample” of her work. In addition, the panel noted that the proved allegations amounted to a pattern of behaviour across Ms Seaward’s case load and were not examples of a “stand alone” or “isolated” instances.

173. The panel accepted that the professional standards relevant at the time were Social Work England 2019 Professional Standards. The panel carefully considered the facts found proved and considered those through the lens of those Professional Standards. The panel found that the standards particularly engaged by Ms Seaward's practice at the relevant time were;

1.3 Work in partnership with people to promote their wellbeing and achieve best outcomes, recognising them as experts in their own lives.

1.4 Value the importance of family and community systems and work in partnership with people to identify and harness the assets of those systems.

2.4 Practice in ways that demonstrate empathy, perseverance, authority, professional confidence and capability, working with people to enable full participation in discussions and decision making.

3.1 Work within legal and ethical frameworks, using my professional authority and judgment appropriately.

3.2 Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision.

3.3 Apply my knowledge and skills to address the social care needs of individuals and their families commonly arising from physical and mental ill health, disability, substance misuse, abuse or neglect, to enhance quality of life and wellbeing.

3.4 Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks. **3.8** Clarify where the accountability lies for delegated work and fulfil that responsibility when it lies with me.

3.9 Make sure that relevant colleagues and agencies are informed about identified risks and the outcomes and implications of assessments and decisions I make.

3.11 Maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions.

3.13 Provide, or support people to access advice and services tailored to meet their needs, based on evidence, negotiating and challenging other professionals and organisations, as required.

174. The panel determined that by falling short of these standards, Ms Seaward had failed to meet the basic standards of practice expected of her as a social worker (in particular at her level and in her role as an experienced adult social worker) and had breached the fundamental tenets of the profession. In particular as a result of her failure to communicate with service users and their families, undertake visits in a timely manner,

progress safeguarding concerns and maintain records. The panel found that by failing to meet the standards, Ms Seaward had put the service users at unwarranted risk of harm.

175. The panel noted that this was in the context of Ms Seaward's demonstrable knowledge and 13 years of professional experience in social care.
176. The panel was mindful of the responses Ms Seaward had given during her employer's investigations. The panel considered whether there was any evidence to support her suggestions that her work might have been adversely impacted by team wide restructuring, a period of time without a permanent manager or a lack of consistent supervision. The panel accepted that such issues might have an impact on an individual's practice but not to the extent demonstrated by the factual findings. The panel also noted that the evidence given by practitioners within the team Ms Seaward had worked in (with the exception of Ms Henry) did not support her comments.
177. The panel noted that the issues raised by Ms Seaward as possible factors impeding her performance, had been resolved by the time of the second set of concerns. By this point, the panel found that the team was well established, with a permanent manager in place and that additional support and supervision had been put in place with the hope that this would allow Ms Seaward to meet the expected level of competence.
178. The panel found that despite the extensive support offered (in particular by Ms Buttar) after her return to work on or around January 2022, Ms Seaward continued to demonstrate the same pattern of failing to meet the basic standards expected of her as a social worker.
179. [PRIVATE].
180. The panel therefore found that the standard of competence demonstrated by Ms Seaward, with reference to a fair sample of her work, was unacceptably low and that the paragraphs of the Allegation found proved amount to the statutory ground of lack of competence.

Finding and reasons on current impairment:

181. When considering the question of impairment, the panel took into account Social Work England's 'Impairment and sanctions guidance'. The panel heard and carefully considered the submissions made by Ms Culleton on behalf of Social Work England and accepted the advice from the legal adviser.
182. In reaching its decision, the panel was mindful of the need to protect the public and the wider public interest in declaring and upholding proper standards of behaviour and maintain public confidence in the profession.
183. The panel first considered whether Ms Seaward's fitness to practise was impaired at the time of the factual concerns. The panel found, for all the reasons set out above that

Ms Seaward had acted in a way that put service users at unwarranted risk of harm and had breached the fundamental tenets of the profession.

184. The panel also found that the conduct had brought the profession into disrepute. The panel had seen evidence of the impact Ms Seaward's conduct had had on service users, their families and other agencies. The panel was left in no doubt that Ms Seaward had damaged the reputation of the profession.
185. The panel went on to consider whether the concerns were objectively remediable. The panel found that in normal circumstances, the lack of competence found by the panel would be capable of remedy. The issues found proved had been in relation to core aspects of social work practice which could ordinarily be addressed by further support, insight, remediation and training.
186. However, the panel was concerned that the witnesses had given clear evidence that Ms Seaward had been able to demonstrate that she knew what needed to be done. The panel was also mindful that Ms Seaward was an experienced social worker at the relevant time and had been provided with ample opportunity following the first concerns to reevaluate her practice and put in place the necessary training and changes. The panel was also mindful that following the first set of concerns, Ms Seaward had been given additional support and supervision. The panel considered that the guidance given following her On Track Chats had been clear and unequivocal about what needed to be done in her cases and by when. The panel was concerned that despite this additional support, Ms Seaward had been unable to demonstrate any real improvement or the requisite competency.
187. The panel found that it had been provided with no evidence to explain the disconnect between Ms Seaward's knowledge and understanding and her inability to put that into practice.
188. The panel found that although the lack of competence was potentially remediable, in the absence of any response from Ms Seaward or explanation as to the reason for the disconnect referred to above, it was left questioning the underlying cause of the significant lack of competence displayed and whether Ms Seaward is capable of remediation.
189. The panel went on to consider whether the lack of competence had been remedied. The panel concluded that it had not. The panel found that Ms Seaward had provided no evidence of insight or remediation during the regulatory process. Furthermore, she had not engaged in any meaningful way. The panel understood that Ms Seaward had not worked as a social worker since the concerns were raised with Social Work England.
190. The panel carefully considered Ms Seaward's response during the internal investigations in reaching this conclusion. The panel found that Ms Seaward's responses failed to demonstrate any insight and an understanding of the impact her conduct would have had on the service users, their family and other professionals. Furthermore, there is no evidence that Ms Seaward appreciated that her shortfalls in

performance would damage the reputation of the profession. The panel found that her responses demonstrated an attempt to transfer blame and responsibility elsewhere, by focussing on her perception of a lack of support and difficulties with the electronic system. As detailed above, the panel accepted that in theory such difficulties may have some impact on a social worker's practice, but that evidence had not been presented to the panel to support this. Nor did the panel accept that such issues could be the determinative reason for Ms Seaward failing to meet the standards to the extent demonstrated.

191. With this in mind, the panel went on to consider whether there is a risk of repetition. The panel concluded that given the lack of insight and remediation there was clearly a risk that if Ms Seaward was to return to practice without restriction she would be highly likely to act in a similar way and therefore put service users at unwarranted risk of harm, bring the profession into disrepute and breach fundamental tenets of the profession.
192. In addition, the panel considered that the risk of repetition had increased by virtue of the fact Ms Seaward had been unable to demonstrate any real improvement, insight or self-reflection during her employer's internal process, which included an escalating level of support and the implementation of a performance improvement plan.
193. The panel therefore concluded that there remains a risk of repetition and that, as a result, Ms Seaward's fitness to practise is currently impaired.
194. In addition, the panel concluded that given the failure to provide any evidence of insight or remediation into the serious concerns into her fitness to practise, a member of the public would be very concerned if a finding of impairment was not made and Ms Seaward was able to return to unrestricted practise.
195. The panel therefore concluded that in these circumstances, a finding of no impairment would undermine public trust and confidence in the profession and Social Work England as a professional regulator. The panel concluded that Ms Seaward's fitness to practise remains impaired on both the public and private grounds.

Decision and reasons on sanction:

196. When considering the question of sanction, the panel took into account the submissions made by Ms Culleton on behalf of Social Work England and the advice received from the legal adviser. The legal adviser reminded the panel that the purpose of a sanction was not to punish Ms Seaward but to protect the public and the wider public interest. The panel were reminded of the sanctions available and of the need to consider any aggravating and mitigating factors it sees fit. The panel was also asked to ensure that when considering sanctions, it begins with the lowest sanction and moves through all the available sanctions in ascending order of seriousness, before identifying the sanction it agrees is sufficient to protect the public and maintain confidence in the profession and uphold professional standards. The panel was reminded that in cases where only lack of competence has been found, a removal order is not an available sanction.

197. The panel also had regard for Social Work England's 'Impairment and sanctions guidance'. The panel went on to identify the following aggravating and mitigating factors, by reference to its determination at the previous stages;

Mitigating factors

- Absence of previous fitness to practise history;
- Some evidence of health issues;
- Some evidence of limited disruptive issues in the workplace during the first set of concerns, including team wide restructuring, a period of time without a permanent manager and a lack of consistent supervision;
- Some evidence of additional support needed for dyslexia and associated difficulties with the technology put in place to give that support.

Aggravating factors

- Repetition of concerns over a 22-month period across a wide range of cases constituting a pattern of behaviour with similar themes;
- Serious short falls across a number of the basic building blocks of social work;
- Lack of improvement following an escalating level of support and the implementation of a performance improvement plan;
- Lack of insight and remorse;
- Lack of remediation;
- Harm and risk of harm to people who used social work services and their families.

198. The panel carefully considered the extent to which it was able to apply weight to the issues of health as a mitigating factor which had been suggested within the papers and identified elsewhere in the determination. The panel found that in the absence of any independent evidence of health issues and Ms Seaward's lack of engagement, it was able to apply limited weight to this issue.

199. The panel was particularly concerned by the impact of Ms Seaward's practice on the service users in her care, their families and the other professionals involved. The panel considered that the role of a social worker is to provide support, assess needs, help to achieve positive outcomes and make progress to enhance Service User's lived experience. Ms Seaward failed to do this in a large number of cases, in a number of different ways, which resulted in significant delays to service users receiving the care and support needed, impacting adversely on family members and other professionals. Furthermore, her persistent shortfalls in practice diminished the reputation of the profession of social work.

200. The panel went on to consider the available sanctions in ascending order.

No further action/Advice or Warning

201. The panel found that given its findings in relation to the risk of repetition, it would not be appropriate to impose a sanction which does not directly restrict practice. The panel also found that such an order would fail to uphold the standards of the profession given the seriousness of the concerns found proved.

Conditions of Practice Order

202. The panel carefully considered the relevant paragraphs within Social Work England's Sanction Guidance and in particular paragraph 114.

203. The panel noted that conditions of practice are commonly applied in cases of lack of competence.

204. However, as detailed above, the panel was concerned that in this particular case, Ms Seaward may not be able to practise safely even with extensive conditions. The panel reached this conclusion in light of the fact that the issues with Ms Seaward's practice continued after she had been given additional supervision, explicit guidance and a performance improvement plan. The panel noted that these measures were similar in purpose to conditions of practice which may be imposed in fitness to practise proceedings. The panel found that the measures imposed on Ms Seaward by her employer had failed to change her practice in any meaningful way. The panel therefore concluded that, based on the information currently available, public protection could not be delivered by a conditions of practice order.

205. The panel also found that given the lack of insight demonstrated and Ms Seaward's failure to engage with the regulatory process, it was not satisfied that Ms Seaward was willing to, or capable of, complying with conditions of practice.

Suspension

206. The panel therefore concluded that a suspension order was the most appropriate sanction. The panel noted that the Sanctions Guidance stated that a suspension order would be appropriate where (both of the following apply):

- the decision-makers cannot formulate workable conditions to protect the public or the wider public interest;
- the case falls short of requiring removal from the register (or where removal is not an option)

207. The panel also found that a period of suspension is necessary to protect the public and uphold the standards of the profession given the panel's findings that the concerns represent a serious breach of the professional standards.

208. The panel considered that the necessary and proportionate period of suspension in this case was two years. The panel reached this conclusion by balancing the need to

protect the public and the wider public interest and the impact of a suspension on Ms Seaward. The panel considered that this would allow Ms Seaward time to engage, reflect and provide evidence of insight and remediation should she decide to reconsider her stated intention to leave the social work profession.

209. Although this panel had no power or intention to bind the hands of a future panel, it recommends that Ms Seaward engage in the future review process and provide evidence of insight and remediation. This may include a detailed written reflective piece, exploring the issues found proved, why they occurred, an understanding of the impact of the failings and what steps have been taken to reduce the risk of future repetition. A future panel is also likely to be assisted by Ms Seaward providing up to date information about her personal circumstances and evidence of remediation. The panel appreciates that Ms Seaward will be unable to provide evidence of her work as a social worker during the intervening period, but hopes that she can provide evidence of situations engaging similar professional attributes and skills, and meaningful references regarding those attributes and skills.
210. The panel notes that in the absence of improved insight or other remediation upon review at the end of the suspension order, a removal order may be an appropriate sanction at that stage.

Interim order:

211. In light of its findings on sanction, the panel next considered an application by Ms Culleton for an interim suspension order to cover the appeal period before the final order becomes effective.
212. The panel heard and accepted the advice of the legal adviser on its power to make an interim order under paragraph 11(1)(b) of Schedule 2 to the Social Workers Regulations 2018.
213. The panel considered whether to impose an interim order. It was mindful of its earlier findings and decided that it would be wholly incompatible with those earlier findings not to impose an interim order. The panel had identified a real risk of repetition if Ms Seaward were permitted to practise without restriction. The panel therefore concluded that an interim order was necessary to ensure the protection of members of the public, to maintain public confidence in the profession and to uphold standards for members of the profession.
214. In determining the appropriate form of interim order, the panel decided that an interim suspension order was necessary and proportionate to address the identified risks during the appeal period. Given the panel's reasons for imposing a suspension order as the substantive sanction, it considered that suspension was the only appropriate interim measure to prevent unrestricted practice.
215. The panel considered that an 18 month order was necessary and proportionate, given that it may take time for any appeal to be scheduled.

216. Accordingly, the panel concluded that an interim suspension order for 18 months is necessary for the protection of the public. When the appeal period expires this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of removal shall take effect when the appeal period expires.

Right of appeal:

217. Under Paragraph 16(1)(a) of Schedule 2 of the regulations, the Ms Seaward may appeal to the High Court against the decision of adjudicators:

- the decision of adjudicators:
 - i. to make an interim order, other than an interim order made at the same time as a final order under Paragraph 11(1)(b),
 - ii. not to revoke or vary such an order,
 - iii. to make a final order.
- the decision of the regulator on review of an interim order, or a final order, other than a decision to revoke the order.

218. Under Paragraph 16(2) of Schedule 2 of the regulations an appeal must be filed before the end of the period of 28 days beginning with the day after the day on which the Ms Seaward is notified of the decision complained of.

219. Under Regulation 9(4) of the regulations this order may not be recorded until the expiry of the period within which an appeal against the order could be made, or where an appeal against the order has been made, before the appeal is withdrawn or otherwise finally disposed of.

220. This notice is served in accordance with Rules 44 and 45 of the Social Work England Fitness to Practice Rules 2019 (as amended).

Review of final orders:

221. Under Paragraph 15(1), 15(2) and 15(3) of Schedule 2 of the regulations:

- 15(1) The regulator must review a suspension order or a conditions of practice order, before its expiry
- 15(2) The regulator may review a final order where new evidence relevant to the order has become available after the making of the order, or when requested to do so by the Ms Seaward
- 15(3) A request by the Ms Seaward under sub-paragraph (2) must be made within such period as the regulator determines in rules made under Regulation 25(5), and a final order does not have effect until after the expiry of that period

222. Under Rule 16(aa) of the rules a Ms Seaward requesting a review of a final order under Paragraph 15 of Schedule 2 must make the request within 28 days of the day on which they are notified of the order.

The Professional Standards Authority:

223. Please note that in accordance with section 29 of the National Health Service Reform and Health Care Professions Act 2002, a final decision made by Social Work England's panel of adjudicators can be referred by the Professional Standards Authority ("the PSA") to the High Court. The PSA can refer this decision to the High Court if it considers that the decision is not sufficient for the protection of the public. Further information about PSA appeals can be found on their website at:
<https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/decisions-about-practitioners>.